STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395651	A. BLDG: 00 B. WING:	05/05/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BIRCHWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **026402**	**395 EAST MIDDLE ROAD NANTICOKE, PA 18634**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance, Abbreviated Complaint and Revisit Survey completed on May 5, 2023, it was determined that Birchwood Healthcare and Rehabilitation Center corrected the federal deficiencies cited during survey of March 28, 2023, but continued to be out of compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0641 SS=D		F 0641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	F 641 Accuracy of Assessments: 1. Resident 3 and resident 80 MDS have had a correction completed. 2. Registered Nurse Assessment Coordinator or Designee will conduct an audit of current MDS assessments for the past 14 days to verify that section N0410 was accurately coded, and corrections will be made. 3. The Registered Nurse Assessment Coordinator or Designee will be re-educated by the Director of Nursing or designee on the validating that the medication section reflects the status of the resident. 4. The Registered Nurse Assessment Coordinator or Designee will conduct random audits section N0410 of the MDS weekly for four weeks then monthly for two months thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0641 SS=D	Continued from page 2 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of two residents out of 19 sampled (Resident 3, and 80). Findings include: A review of Resident 3's annual MDS Assessment dated March 8, 2023, indicated in Section N0410 Medications Received that an antipsychotic medication was received seven times in the last seven days. Review of the Resident 3's March 2023	F 0641		

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F 0641 SS=D	Continued from page 3 Medication Administration Record (MAR) revealed that the resident did not receive any antipsychotic medications during the 7 day look back period. A review of Resident 80's quarterly MDS Assessment dated February 6, 2023, revealed in Section N0410, "Medications Received," that Resident 80 received one anticoagulant medication during the 7 days of the lookback period. However, a review of the Medication Administration Record (MAR) for January 2023 and February 2023 indicated that Resident 80 did not receive an anticoagulant medication during the entire 7 days of the lookback period. During an interview with the nursing home administrator (NHA) on May 3, 2023, at	F 0641		

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F 0641 SS=D	Continued from page 4 approximately 9:15 a.m., the NHA confirmed that Resident 3 and Resident 80 MDS assessments were inaccurate with respect to medications received. 28 Pa. Code 211.5(g)(h) Clinical records 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services	F 0641		
F 0644 SS=D		F 0644		

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F 0644 SS=D	Continued from page 5 483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 0644	F 644 Coordination of PASARR and Assessments: 1. Resident 29 has been discharged from facility. 2. Social Services Director or Designee will conduct an initial audit of current residents that have a level 2 PASSAR has appropriate services offered. 3. The Nursing Home Administrator or designee will re-educate social services on verifying that PASSAR services are offered when identified. 4. Social Services Director or Designee will conduct random audits of new admissions with PASSAR level 2 determinations to verify services are offered weekly for four weeks then monthly for two months thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0644 SS=D	Continued from page 6 Based on clinical record review and staff interview, it was determined that the facility failed to incorporate the recommendations from the Pre-Admission Screening and Resident Review (PASARR) level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care for one of three residents reviewed (Resident 29). Findings include: Review of clinical record of Resident 29 revealed diagnoses to include Bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania or hypomania] and lows [depression]). Further review of Resident 29's clinical	F 0644		

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F 0644 SS=D	Continued from page 7 record revealed a PASARR Level I (federally required assessment to help ensure that all individuals with serious mental disorders and/or intellectual disabilities are not inappropriately placed in nursing homes for long term care) dated August 11, 2022, with the following outcome: "Individual has a positive screen for Serious Mental Illness, Intellectual Disability, and/or Other Related Condition; requires further evaluation (Level II)." A PASARR Level II determination letter dated August 15, 2022, indicated that "you do not meet the mental health criteria for further review from our office. We will be forwarding your information to the offices of Developmental Programs and Long Term Living for further evaluation in regards to your intellectual disability and	F 0644		

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F 0644 SS=D	Continued from page 8 related condition. " A PASARR Level II determination letter dated August 16, 2022, indicated that "you have been determined eligible for the level of services provided by a nursing facility and services for an individual with Intellectual Disability (ID). Additional ID specialized services are available for individuals who reside in a nursing facility. These services can include training, treatments, therapies and related services to help people function as independently as possible." Review of Resident 29's current care plan conducted during the survey ending May 5, 2023, revealed no care plan developed in relationship to the PASARR II determination. The care plan failed to identify the individual and specific	F 0644		

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F 0644 SS=D	Continued from page 9 services recommended and/or provided to the resident as the result of the resident's Intellectual Disability and PASARR II. An interview with the Director of Nursing on May 5, 2023 at 10:00 a.m. confirmed that the PA-PASARR-ID II form completed had identified Resident 29 as a target resident and were unable to provide evidence of coordination of specific specialized services and inclusion on the resident's care plan There was no evidence at the time of the survey that the facility had timely identified and coordinated the provision of specialized services for Resident 29 based on the results of the PASARR.	F 0644		

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F 0644 SS=D	Continued from page 10 28 Pa. Code 211.16(a)(b) Social Services 28 Pa. Code 211.11 (d)(e) Resident care plan 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services 28 Pa. Code 211.5(f) Clinical Records	F 0644		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 11 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	F 688 Increase/Prevent Decrease in ROM/Mobility: 1. Resident 24 was evaluated and started on a PROM RNP to prevent contractures. Resident 87 was evaluated by therapy and started on a restorative nursing program. 2. Director of Nursing or Designee will conduct an initial audit of current residents with restorative programs that have been started in the last 30 days to verify nursing services are planned to maintain functional abilities. 3. The Director of Nursing or Designee will re-educate nursing and therapy staff on the restorative nursing policy with the focus on documentation. 4. The DON or designee will conduct random audits to verify restorative programs are in place and being documented as per the plan of care weekly for four weeks then monthly for two months thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0688 SS=E	Continued from page 12	F 0688	Committee and changes will be made as necessary.	

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F 0688 SS=E	Continued from page 13 Based on clinical record review, resident, family and staff interview, it was determined that the facility failed to provide restorative nursing services planned to maintain the functional abilities of two of five sampled residents (Residents 24 and 87). Findings include: A review of the clinical revealed that Resident 24 was admitted to the facility on May 23, 2022, with diagnoses of paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs), diabetes and depression. A significant change Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan	F 0688		

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F 0688 SS=E	Continued from page 14 resident care) dated February 26, 2023, indicated that Resident 24 was severely cognitively impaired, and the resident required extensive staff assistance of two staff members for all Activities of Daily Living (ADLs). Physical therapy discharge summary dated June 14, 2022, indicated that Resident 24 was to receive Restorative Nursing services. A Restorative Nursing Program (RNP) was to be established for passive range of motion (PROM) to the lower extremities upon the resident's discharge from skilled physical therapy. There was no documented evidence that the above RNP planned for PROM to the resident's lower extremities at the time of discharge from skilled therapies on June 14, 2022, through the time of the survey	F 0688		

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F 0688 SS=E	Continued from page 15 ending May 5, 2023, had been implemented. Interview with the Resident 24's wife on May 2, 2023 at 11:30 a.m. revealed that she had never observed facility staff performing passive range of motion exercises on the resident during her frequent visits to the facility. A review of the clinical record revealed that Resident 87 was admitted to the facility on April 21, 2022, with diagnoses that have included diabetes, chronic obstructive pulmonary disease (COPD), ulcerative colitis, right hemiplegia/hemiparesis (condition that causes weakness or paralysis on one side of the body), and right lower leg muscle contracture.	F 0688		

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F 0688 SS=E	Continued from page 16 A quarterly MDS dated February 17, 2023, indicated that Resident 87 was cognitively intact with a BIMS (brief interview mental screener completed to assess cognitive function) score of 14 (a score of 13-15 indicates cognitively intact), and the resident required extensive staff assistance, 2 staff members, for bed mobility, transfer, and toileting, and 1 staff member for dressing, and personal hygiene. A review of Resident 87's care plan initiated April 21, 2022, indicated that the resident was at risk for activities of daily living (ADL) self - care deficit related to physical limitations hemiplegia, hemiparesis. Care planned interventions/tasks to assist/prevent declines in ADL abilities were to provide a restorative nursing program (RNP), range	F 0688		

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F 0688 SS=E	Continued from page 17 of motion: active range of motion (AROM) to left upper extremity (LUE) / left lower extremity (LLE), and passive range of motion (PROM) to right upper extremity (RUE) and right lower extremity (RLE) as tolerated. A physical therapy discharge summary dated March 15, 2023, indicated that upon discharge from skilled rehab services, Resident 87 was to receive Restorative Nursing services. A Restorative Nursing Program (RNP) was to be established for RLE, AROM into all planes of motion for 2 x 10 reps to prevent further contracture. Staff to provide gentle stretching to have RLE into proper alignment before AROM. Knee flexion contracture noted on RLE. A review of restorative nursing document	F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395651	A. BLDG: 00 B. WING:	05/05/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BIRCHWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **026402**	**395 EAST MIDDLE ROAD NANTICOKE, PA 18634**

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F 0688 SS=E	Continued from page 18 entitled, "documentation survey report", dated for April 2023, indicated nursing rehab included the following tasks for Resident 87: AROM LUE/LLE, PROM RUE/RLE as tolerated. However, nursing entered several entries of "NA", "RR", and multiple several blank spaces, when recording the provision of those services to Resident 87 as planned. A continued review of the resident's clinical record and care plan, failed to identify his refusal of care, services, or the planned restorative nursing program. Interview with Director of Rehabilitation on May 4, 2023, at approximately 11:10 AM, confirmed that "NA" indicated not applicable, "RR" indicated resident refusal, and that blank spaces indicated that either the task was not completed or	F 0688		

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F 0688 SS=E	Continued from page 19 not documented. She acknowledged that the documentation survey report did not include the number of repetitions for each exercise (2 x 10 reps) or the task for staff to provide gentle stretching to have RLE into proper alignment before AROM, as indicated on the Physical Therapy (PT) discharge summary. The Director of Rehab confirmed that the PT discharge summary dated March 15, 2023, did not include the exercises to left upper or lower extremity. A review of the documentation survey report of the provision of the RNP to Resident 87 during the month of April 2023, indicated that staff failed to document the provision of the services, or noted that the resident refused the program or that the task was not applicable on April 1, 2, 8, 9, 22, 23, and	F 0688		

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F 0688 SS=E	Continued from page 20 26, 2023. Interview with alert and oriented Resident 87, on May 2, 2023, at approximately 11:15 AM, and on May 4, 2023, at 11:01 AM, revealed that the resident stated that nursing staff is not providing him the restorative nursing program and that he does not refuse to be exercised. Interview with the Nursing Home Administrator (NHA), on May 4, 2023, at approximately 11:25 AM, confirmed the above findings, and acknowledged the facility failed to provide restorative nursing services as planned. 28 Pa. Code: 211.5(f) Clinical records	F 0688		

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F 0688 SS=E	Continued from page 21 28 Pa Code 211.12 (a)(c)(d)(3)(5) Nursing services	F 0688		
F 0699 SS=D		F 0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0699 SS=D	Continued from page 22 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	F699 Trauma Informed Care: 1. Resident 34 has had an individualized trauma informed care plan developed. 2. The Social Service Director or Designee will conduct an initial audit of current resident's trauma assessments to verify that resident's needs are addressed. 3. The Administrator or Designee will re-educate social services on developing trauma informed care plans found on initial assessments. 4. The Social Service Director or Designee will conduct random audits of current resident's trauma assessments to verify that resident's needs are addressed. This will be completed weekly for four weeks then monthly for two months thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0699 SS=D	Continued from page 23 Based on a review of clinical records and staff interviews, it was determined that the facility failed to develop and implement an individualized trauma-informed care plan that accounted for the 19 residents sampled (Resident 34). Findings include: A clinical record review revealed that Resident 34 was admitted to the facility on July 14, 2020, with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), major depressive disorder, generalized anxiety disorder, and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions). Review of the most recent quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment tool conducted at specific	F 0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0699 SS=D	Continued from page 24 intervals to plan a resident's care) dated February 3, 2023, indicated that the resident is severely cognitively impaired with BIMS score of 3 (Brief Interview for Mental Status, 0-7 indicates severe cognitive impairment). Resident 34 has a physician's order, active since July 14, 2020, to receive psychological evaluation and treatment as needed by Supportive Care (psych service provider). A Psychological Services Psychosocial Evaluation for Supportive Care and Comprehensive Trauma Screening conducted on December 1, 2022, revealed that Resident 34 had witnessed a traumatic situation, has a history of trauma, and has the cognitive ability and verbal capacity to participate in and benefit from psychotherapy. Specifically, the consultation recommended individual psychotherapy to reduce emotional symptoms. Resident 34's care plan, subsequent to the December 1, 2022, psychological evaluation,	F 0699		

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F 0699 SS=D	Continued from page 25 through the time of the survey ending on May 5, 2023, revealed no evidence that the facility incorporated the resident's history of trauma into the resident's care plan or that the facility identified potential triggers associated with the resident's past traumatic experiences. Also, there was no evidence that the facility developed specific interventions for staff to provide individualized trauma-informed care for Resident 34. An interview with the Nursing Home Administrator and employee 9 (social services) on May 3, 2023, at approximately 1:00 p.m. confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to provide individualized trauma-informed care. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.11(d) Resident care plan.	F 0699		

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F 0699 SS=D	Continued from page 26	F 0699		
F 0745 SS=E		F 0745		

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F 0745 SS=E	Continued from page 27 483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0745	F745 Provision of Medically Related Social Service: 1.No adverse events occurred from findings. R34 will have follow up with psychosocial counseling. R60 will be offered services to meet the resident's psychosocial needs. R87 was explained their services available to meet his psychosocial needs and nursing to schedule appointments/labs when needed. R16 has meet appointment identified and social services will provide psychosocial services as needed and business office will discuss any billing issues resident has. 2. Social Service Director or Designee will conduct a fourteen day look back of current resident's progress notes to identify any resident's psychosocial needs have been met. 3. The Nursing Home Administrator will re-educate social services on providing timely psychosocial services. 4. Social Service Director or Designee will conduct random audits of current resident's progress notes	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/19/2023**

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F 0745 SS=E	Continued from page 28	F 0745	to identify any resident's psychosocial needs have been met. This will be completed weekly for four weeks then monthly for two months thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement Committee and changes will be made as necessary. 2. Social Service Director or Designee will conduct a fourteen day look back of current resident's progress notes to identify any resident's psychosocial needs have been met. 3. The Nursing Home Administrator will re-educate social services on providing timely psychosocial services. 4. Social Service Director or Designee will conduct random audits of current resident's progress notes to identify any resident's psychosocial needs have been met. This will be completed weekly for four weeks then monthly for two months thereafter to verify	

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F 0745 SS=E	Continued from page 29	F 0745	documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement Committee and changes will be made as necessary.	

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F 0745 SS=E	Continued from page 30 Based on a review of clinical records and resident and staff interviews, it was determined that the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of three of the 19 residents reviewed (Residents 34, Resident 60, Resident 87 and Resident 16). Findings include: Clinical record review revealed that Resident 34 was admitted to the facility on July 14, 2020, with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), major depressive disorder, generalized anxiety disorder, and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions). A quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment tool	F 0745		

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F 0745 SS=E	Continued from page 31 conducted at specific intervals to plan a resident's care) dated February 3, 2023, revealed that the resident was severely cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status, a score of 0-7 indicates severe cognitive impairment). Resident 34 has a current physician's order, initially dated July 14, 2020, to receive psychological evaluation and treatment as needed by Supportive Care (psych service provider). A review of Resident 34's clinical record revealed a Psychological Services Psychosocial Evaluation for Supportive Care and Comprehensive Trauma Screening conducted on December 1, 2022. The assessment indicated that Resident 34 has the cognitive ability and verbal capacity to participate in and benefit from psychotherapy, that treatment is justified based on Resident 34's ability to perform in therapy, and that Resident 34's condition would deteriorate if the patient did not participate in psychotherapy or if treatment was discontinued.	F 0745		

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F 0745 SS=E	Continued from page 32 Additionally, the consultation recommended individual psychotherapy to reduce emotional symptoms. The session summary indicated that the next psychotherapy session "is in 1 week, frequency 1-5 x monthly." A review of Resident 34's clinical record following the December 1, 2022, Psychological Evaluation for Supportive Care through the time of the survey ending on May 5, 2023, revealed no documented evidence of additional coordination of mental and psychosocial counseling services for Resident 34. Interviews with the Nursing Home Administrator and employee 9 (social services) on May 3, 2023, at approximately 1:00 p.m. confirmed the facility was unable to provide evidence of providing or arranging mental and psychosocial counseling services to attain or maintain Resident 34's psychosocial well-being following the December 1, 2022, Psychological Evaluation for Supportive Care.	F 0745		

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F 0745 SS=E	Continued from page 33 Clinical record review revealed that Resident 60 was admitted to the facility on March 23, 2023, with diagnoses which included dementia. Review of Resident 60's admission MDS dated March 29, 2023, indicated that the resident's BIMS score was 4 indicating severe cognitive impairment, required one person physical assistance for mobility and transfers, and ambulated with supervision. The resident participated in the assessment and expected to be discharged to the community. The assessment noted that active discharge planning was in place, and a referral was not needed to local contact agency. Review of the resident's care plan, initially dated March 23, 2023, indicated that the resident's need for discharge planning, for a discharge to the most appropriate level of care, was resolved on April 10, 2023. On April 10, 2023, the resident's care plan was revised to indicate that the resident does not show potential for discharge to the community due to physical care needs and indicated care needs will	F 0745		

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F 0745 SS=E	Continued from page 34 continue to be met at the facility. Interventions planned were to provide support to the resident, family and/or representative as needed. Review of a social services note dated March 30, 2023, indicated that Resident 60's relative would be "stepping away from everything" and noted that a request to start the Guardianship process (representative appointed by the state law to act on the resident's behalf) based on the resident's cognitive status and the resident's relative's inability to make decisions for the resident was made by the resident's relative. A social services note dated April 6, 2023 indicated that completed documents to initiate Guardianship for Resident 60 were forwarded to the appropriate agency. Interview with Resident 60 on May 4, 2023, at 10:30 AM revealed that the resident was confused, but was able to answer questions regarding his care and preferences. Resident 60 stated that his family	F 0745		

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F 0745 SS=E	Continued from page 35 lived away and had their own health issues. Resident 60 stated that he was a veteran and would be interested in any services he would be entitled to as a veteran. He stated that he was satisfied at the facility currently, but did make reference to his apartment in the community during the conversation. Further review of the clinical record failed to provide documented evidence of individualized medically related social services to provide support to Resident 60 including the resident's change in discharge plans and family involvement due to his family's wishes for a legal guardian to be appointed. There was no documented evidence that based on the resident's veteran status that the facility had explored potential services to which the resident may be entitled. Interview with the employee 8 (social services) on May 5, 2023, at approximately 11:30 AM failed to provide documented evidence of individualized medically-related social services provided to Resident 60 to address the resident's psychosocial	F 0745		

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	395651	A. BLDG: __00_____ B. WING: _____	05/05/2023

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F 0745 SS=E	Continued from page 36 needs regarding the need for long term placement at the facility and a legal Guardian to assist with decision making. A review of the clinical record revealed that Resident 87 was admitted to the facility on April 21, 2022, with diagnoses that have included diabetes, chronic obstructive pulmonary disease (COPD), ulcerative colitis, right hemiplegia/hemiparesis (condition that causes weakness or paralysis on one side of the body), and right lower leg muscle contracture. A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 17, 2023, indicated that Resident 87 was cognitively intact with a BIMS (brief interview mental screener completed to assess cognitive function) score of 14 (a score of 13-15 indicates cognitively intact). A review of the clinical record revealed an entry	F 0745		

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F 0745 SS=E	Continued from page 37 dated March 24, 2023, at 11:33 AM, revealed that the resident refused blood work. The resident, whose payor source is Medical Assistance, stated that he was billed $1000 last time he had blood work done. An entry dated March 25, 2023, at 12:24 AM, revealed that the resident repeatedly refused his Lipid panel, LFT's, Hgb A1c, Vitamin D level Q 3 months, which are ordered every shift every 3 month(s) starting on the 23rd for 3 day(s) for medication monitoring. An entry dated March 26, 2023, at 1:08 PM, revealed that the resident refuses to let them take bloodwork due to billing issues with the previous times he had blood work. Interview with the Business Office Manager (BOM), on May 3, 2023, at approximately 9:25 AM, revealed that she not made aware of the resident's concern, billing and verified that Resident 87 payor source was Medical Assistance (MA) and	F 0745		

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F 0745 SS=E	Continued from page 38 shouldn't have been billed. Interview with alert and oriented Resident 87, on May 4, 2023, at approximately 11:01 AM, revealed that no one from the facility, including Social Services, and or the Business Office addressed this billing issue, nor spoke with him about this. He further stated he resolved the billing issue on his own. A review of the clinical record revealed that Resident 16 was most recently admitted to the facility on February 14, 2023, with diagnoses to have include protein - calorie malnutrition, dementia, anxiety, and depression. A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan a resident's care) dated January 18, 2023, revealed that the resident was severely cognitively impaired with a BIMS (brief interview mental screener completed to assess cognitive function) score of 3 (a	F 0745		

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F 0745 SS=E	Continued from page 39 score of 0-7 indicates severe cognitive impairment) and required extensive staff assistance, with 1 staff member, for transfers, dressing, toilet use, and personal hygiene, and limited staff assistance, with 1 staff member for bed mobility. Nursing documentation dated February 1, 2023, at 9:20 AM revealed that the resident unable to bear weight on right lower extremity (RLE), keeping heel up off floor. An order was received for an x-ray of the resident's right lower extremity. Nursing noted on February 3, 2023, at 2:20 PM, that the resident was transported to an orthopedic appointment. However, additional nursing documentation dated February 3, 2023, at 3:15 PM, indicated that that transport staff returned to the facility with resident at this time. Nursing noted that orthopedist refused to see the resident today because no facility staff member or family member was present with the resident. The resident's appointment was	F 0745		

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F 0745 SS=E	Continued from page 40 rescheduled for Monday February 6, 2023. There was no documented evidence that medically related social services had been provided in coordinating the resident's need for outside orthopedic services to ensure that the facility was aware of the need that facility staff or family were required to accompany the resident to the appointment resulting in a delay in the resident's appointment and requiring the resident to be transported again to the rescheduled appointment on February 6, 2023. Nursing noted on February 9, 2023, at 2:44 PM, that the resident returned from the orthopedic appointment accompanied by EMS. Nursing noted that the family will discuss if they want her to have a surgical intervention, but at this time, they believe she is not in significant pain, and if her pain does increase, and she is uncomfortable, they will decide to have the procedure performed. Interview with the Director of Nursing (DON) on	F 0745		

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F 0745 SS=E	Continued from page 41 May 3, 2023, at approximately 10:30 AM, confirmed that the resident was returned from the orthopedic appointment without being seen on February 3, 2023, thus causing a delay in services and requiring another transport, the following Monday. The DON confirmed that Resident 16 is severely cognitively impaired, and required extensive staff assistance with transfers, dressing, and toilet use, which are activities of daily living, which may be required while at the doctor's appointment and the facility had failed to assure that staff or interested family had accompanied the resident. 28 Pa. Code 211.5(f)(g)(h) Clinical Records 28 Pa. Code 211.16 (a) Social Services. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services 28 Pa. Code 201.29 (j) Resident Rights	F 0745		

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F 0745 SS=E	Continued from page 42	F 0745		
F 0806 SS=E		F 0806		

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F 0806 SS=E	Continued from page 43 483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 0806	F 806 Resident Allergies, Preferences, Substitutes: 1. The dietician has met with resident 67 and resident 57 and has updated their individual food preferences. 2. The Dietician or Designee will review individual food preferences with the current residents to verify needs are met. 3. The Dietician or Designee will re-educate dietary staff on importance of ensuring the residents are receiving the food preferences of choice. 4. The Dietician or Designee will conduct random audits of food preferences with the current residents to verify needs are met. This will be completed weekly for four weeks then monthly for two months thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0806 SS=E	Continued from page 44 Based on observation, a review of facility's planned menus and resident and staff interview it was determined that the facility failed to consider individual food preferences, to the extent possible, to increase resident satisfaction with meals for residents which included Residents 67 and 57. Findings include: During an individual interview on May 3, 2023, at 1:00 p.m. with Resident 67 the resident stated that at times, she does not receive foods that she would like or the foods identified to be served noted on her meal tray ticket. Review of the resident's meal tray ticket for breakfast served on April 26, 2023, revealed that the meal ticket noted that the	F 0806		

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F 0806 SS=E	Continued from page 45 resident was to receive orange juice, cheese omelet, wheat toast, margarine, oatmeal, skim milk, coffee, and creamer. The resident stated that she did not receive the orange juice, margarine, skim milk, or creamer. She also stated that white toast was substituted for wheat toast and cream of wheat was substituted for oatmeal without prior notification from the resident. The resident also stated that skim milk was missing from her breakfast tray and when she requested the missing beverage, she received whole milk instead of skim milk. Review of her meal tray ticket for the breakfast served on April 30, 2023, revealed that the meal ticket noted that the resident was to receive assorted cold cereal and skim milk. The resident stated that she was not served any cold cereal	F 0806		

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F 0806 SS=E	Continued from page 46 and was provided whole milk on her tray, instead of her preferred skim milk. Review of her meal tray ticket for lunch meal on April 30, 2023, revealed that the resident's meal ticket noted that the resident was to receive turkey breast, savory bread dressing, a dinner roll, margarine, and blueberry pie. The resident stated that she did not receive the savory bread dressing, dinner roll, margarine, and blueberry pie. She stated that she received mashed potatoes (which were not on the menu) and a hardened chocolate chip cookie for dessert. Review of her meal tray ticket for lunch on May 1, 2023, revealed that the resident was to receive meatloaf, garlic mashed potatoes, broiled tomato half, dinner roll, margarine, chocolate chip brownie bar,	F 0806		

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F 0806 SS=E	Continued from page 47 and fresh fruit. The resident stated she did not receive the broiled tomato half, dinner roll, margarine, and fresh fruit. She stated that she was served rice instead of garlic mashed potatoes and a chocolate chip brownie bar instead of fresh fruit. The resident stated that she did not receive prior notice of these substitutions. Review of her meal tray ticket for the lunch meal on May 2, 2023, revealed that she was to receive a crab cake, baked potato, dinner roll, margarine, apple crisp, and tarter sauce. The resident stated that she did not receive the dinner roll, margarine, and apple crisp. Additionally, the resident stated that the baked potato was very hard and not baked long enough. Interview with the Administrator on May	F 0806		

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F 0806 SS=E	Continued from page 48 4, 2023 at 11:15 a.m. revealed that the NHA was unable to explain why Resident 67 did not receive preferred foods and the foods and beverages noted on her meal tray ticket. Observation on May 2, 2023 at 12:20 PM revealed that Resident 57 was served lunch in his room as per his preference. Interview with the resident at this time revealed that he received a crab cake for his entrée. The resident stated that he told them (the facility) in the past that he does not like fish or seafood. Observation of the resident's meal ticket revealed that he should have received a crispy pork chop instead of a crab cake. Interview with the registered dietitian on May 3, 2023 at approximately 1:30 PM confirmed that Resident 57's meal ticket	F 0806		

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F 0806 SS=E	Continued from page 49 should have been followed to ensure the resident was provided food items based on his preferences. 28 Pa. Code 211.6 (a)(c)(d) Dietary services 28 Pa. Code 201.29 (j) Resident rights	F 0806		

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F 0806 SS=E	Continued from page 50	F 0806		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 51 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	F 812 Food Procurement,Store/Prepare/Serve-Sanitary: 1. Identified areas have been corrected immediately (Food placed on floor, shelf-life items and dates, equipment broken has been replaced). 2. The Dietician or Designee will conduct an initial kitchen and kitchenette walk through to identify that the environment is clean, equipment is not broken, and food is stored properly. Issues identified will be corrected immediately. 3. The Dietitian or Designee will re-educate the dietary staff on clean environment, equipment identified and corrected, and food is stored properly. 4. The Dietician or Designee will conduct random kitchen and kitchenette audits to identify that the environment is clean, equipment is not broken, and food is stored properly. Any issues identified will be corrected immediately. This will be completed weekly for four weeks then monthly for two months	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0812 SS=F	Continued from page 52	F 0812	thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance Performance Improvement Committee and changes will be made as necessary.	

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BIRCHWOOD REHABILITATION & HEALTHCARE CENTER	**395 EAST MIDDLE ROAD NANTICOKE, PA 18634**
STATE LICENSE NUMBER: **026402**	

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F 0812 SS=F	Continued from page 53 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department and two of two resident pantry areas. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).	F 0812		

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F 0812 SS=F	Continued from page 54 Initial tour of the food and nutrition services department in the presence of the registered dietitian on May 2, 2023, at 8:40 AM, revealed the following sanitation concerns with the potential to introduce contaminants into food and increase the potential for food-borne illness: Observation of the walk-in freezer revealed that there were cases of frozen food stacked in a column with a case of frozen spinach in direct contact with the floor. The registered dietitian confirmed the food was just delivered and needed to be place on the shelves. There was an approximate seven-inch crack in the plastic cover of the bulk sugar container. There was an ice scoop and wet soiled cleaning rag laying on top of the ice machine. There was an opened container of honey thickened iced tea with a date of "April 13" written on the container on the shelf in the walk-in cooler. The	F 0812		

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F 0812 SS=F	Continued from page 55 manufacturer label on the container noted the beverage was to be used within 10 days of opening. There was a pitcher of cranberry juice on the shelf in the walk-in cooler which was not dated. The floors of the perimeter of the kitchen were visibly soiled and in need of cleaning. There was a garbage can, which contained garbage without a lid in the food production area of the kitchen. Observation of the second-floor resident pantry on May 4, 2023, at 12:50 PM revealed a pitcher of a red colored beverage, which was labeled apple juice. There was a sticky label residue adhered to the surface of the pitcher. Observation of the first-floor resident pantry on May 4, 2023 at 1:00 PM revealed there were two peanut butter and jelly sandwiches on the shelf in the refrigerator which were not dated. There were 15	F 0812		

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F 0812 SS=F	Continued from page 56 four-ounce containers of Healthshakes (a nutritional beverage) on the shelf in the refrigerator which were not dated with a discard dated. The manufacturer label noted the Healthshakes should be discarded after 14 days of thawing. Interview with the registered dietitian on May 4, 2023 at approximately 1:45 PM confirmed that acceptable practices for food storage were to be followed and all food storage areas were to be maintained in a sanitary manner. 28 Pa. Code 211.6 (c) Dietary services. 28 Pa. Code 207.2(a) Administrator's responsibility.	F 0812		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 57 483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	F 849 Hospice Services: 1. Resident 24's care plan has been integrated with hospice services and measures to assure that the delivery of care meets the individual needs of the resident. 2. Director of Nursing or Designee will conduct an initial audit of residents' receiving hospice services to verify that the facility has coordinated resident care with hospice to meet the needs of the resident. 3. The DON or designee will re-educate licensed nurses on importance of integrating resident care with hospice services and measure to assure that the individual need of the resident is met. 4. The Director of Nursing or Designee will conduct random audits of hospice care plans to verify that the care has been integrated with hospice services. This will be completed weekly for four weeks then monthly for two months thereafter to verify documentation is accurate. Results of the audits will be reviewed at Quality Assurance	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0849 SS=D	Continued from page 58 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	Performance Improvement Committee and changes will be made as necessary.	

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F 0849 SS=D	Continued from page 59 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849 SS=D	Continued from page 60 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849 SS=D	Continued from page 61 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849 SS=D	Continued from page 62 Based on clinical record review and staff interview, it was determined that the facility failed to ensure coordination of Hospice services with facility services to meet the resident's needs on a daily basis for one out of one resident reviewed receiving hospice services (Resident 24). Findings include: A review of the clinical record revealed that Resident 24 was admitted to the facility on May 23, 2022, with diagnoses of diabetes and depression. The resident was admitted to hospice services on February 23, 2023 for Dementia (senile degeneration of the brain). Review of Resident 24's plan of care	F 0849		

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F 0849 SS=D	Continued from page 63 conducted during the survey ending May 5, 2023, revealed the plan of care was not integrated with hospice services and measures planned to assure that nursing home staff monitor the delivery of care in order to assure that the hospice provides services to the resident meets the resident's needs. There was no evidence that the hospice and the nursing home collaborated in the development of a coordinated plan of care for each resident receiving hospice services to identify the provider responsible for performing each or any specific services/functions that have been agreed upon and the location of the necessary plans. Interiew with the Director of Nursing on May 3, 2023, at 10:30 a.m. she confirmed	F 0849		

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F 0849 SS=D	Continued from page 64 that hospice care plans were not integrated with the facility plans of care. 28 Pa. Code 211.11 (d) Resident care plan 28 Pa. Code 211.12 (d)(3)(5) Nursing services	F 0849		

Certified End Page

BIRCHWOOD REHABILITATION & HEALTHCARE CENTER

STATE LICENSE NUMBER: 026402

SURVEY EXIT DATE: 05/05/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

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